The Financial Implications of Compulsory Health Insurance*

By

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Any discussion of "The Financial Implications of Compulsory Health Insurance"—particularly by an actuary, and before an audience such as this—should, I think, begin by stating some fundamental definitions, and considering certain basic propositions, in order that the various matters which present themselves for investigation may be quite clear.

Since I am speaking in British Columbia, where a Health Insurance Bill has been actively under discussion for several years without agreement on its terms having been reached, I shall necessarily frame some of these observations on the circumstances underlying that particular legislation. In so doing, however, I ask you, in all sincerity, to interpret my remarks as being prompted solely by a desire to secure, for any such measure which may ultimately be adopted in Canada, the soundest possible financial basis and the fullest degree of co-operation.

My desire for a sound financial basis is natural, of course, to an actuary—for reasons which I shall explain.

The hope that real co-operation may be attained between the Government and the medical profession arises in my case with perhaps special force because my own father was a doctor. I was brought up in a household where the devotion of physicians was a matter of daily observation, and the attainments and ethics of the medical profession occupied a very honoured place.

THE MEANING AND CAPACITY OF HEALTH "INSURANCE"

I should, accordingly, like to direct your attention first of all to the meaning of "Health Insurance." Even though it entails repeating what has so often been explained, it may be said that "Insurance" involves the co-operative association of a large number of persons, who agree to share amongst themselves the burdens arising from the occurrence of a particular contingency—in this case sickness—by the payment of the necessary contributions into a common fund, from which benefits, related strictly to those contributions, are distributed in alleviation of the burdens against which the insurance is effected.

"Insurance" thus defined is not in any sense a new, or even a recent, concept. It is not, I think, generally appreciated that voluntary societies for insurance against the losses resulting from sickness existed in Europe centuries ago. Over the intervening period, and especially during the last 140 years, a very extensive experience has been gained in the evolution of certain fundamental principles and practical methods of procedure. A great body of statistical data has also been accumulated and systematically analyzed. The actuary may now therefore be said, quite properly, to be in a position to embark upon the preparation of the necessary estimates and regulations for any scheme of health insurance with much valuable material—and yet with a very salutary degree of caution. Again at the risk of repeating well established facts, I should like in this connection to ask you to note that the rate of sickness in any community, or scheme, has been shown to depend upon a great variety of circumstances, of which the most significant are age, sex, marital condition, occupation, personal and family history, locality of domicile, and economic status. Moreover, while these are the major influences determining the rates at which illnesses actually occur, it is important to remember that the introduction of any plan which offers either benefits in cash or benefits in kind immediately brings into prominence the psychology and ethics of the persons insured, so that the rate at which claims for sickness benefits are made shows marked differentiation from the previously mentioned rate at which the sicknesses actually arise. The factors which thus, in addition to those already enumerated, have a significant effect upon the rate of claim—and therefore upon the financial experience of any insurance plan—are:

Firstly—the "qualifying period," i.e., the period which must be passed before the insured person first becomes eligible to file a claim.

Secondly—the "waiting period," that is to say, the number of days of sickness which must elapse before payment of any cash benefit shall commence.

Thirdly—the "benefit period," being the length of time for which benefits will be paid.

Fourthly—the so-called "periods of attack," generally used in the case of benefits in cash, by which the claims are segregated according to their incidence in, for example, the "first three months" of claim, "second three months," "second six months," etc.

Fifthly—the "re-qualifying" period, during which eligibility must be re-established after exhaustion of any benefit period.

Sixthly—the relation of the character and amount of the benefit to the normal standard of living and earnings of the claimant prior to the occurrence of the sickness, and,

Lastly—the nature and size of the organization through which the payment of benefits is obtainable, and the facilities for and regulations governing the filing of claims, their medical certification, and their final scrutiny.

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* An Address delivered before the Sixth Canadian Conference on Social Work, Vancouver, B.C., July 21, 1938.

—Reprinted from the Vancouver Medical Bulletin, July, 1938, by kind permission of the author and the editor.

All that sounds, I well know, a formidable recital; in many ways almost every one of these factors presents a difficult problem of calculation and administration. Yet they must all be taken into account. If they are not clearly understood by both the administrators of any plan, and the insured persons who are to be covered by it, the result inevitably will be wide-spread dissatisfaction. Any scheme of "health insurance" must accordingly be based on certain definite principles and regulations; it cannot promise or attempt to give benefits on an unrestricted scale—to do so would mean financial bankruptcy for the plan, and loss and disappointment for those who had thought they were "insured."

THE MEANING OF THE PHRASE "ACTUARIALLY SOUND"

In connection with these explanations of the meaning of "insurance," I now wish to ask your attention to an important matter which next, in logical order, arises for consideration, and which, I think, has been somewhat misunderstood in many of the discussions surrounding the British Columbia Act. I refer to the meaning of the phrase "actuarially sound."

By way of introduction, I should describe briefly the functions and duties of the actuary. The designation "actuary" was first used officially in the deed of settlement of the old Equitable Society, founded in London for the insurance of lives over 175 years ago. Charged originally merely with keeping the registers of the risks carried on the books of the insuring institution, the actuary soon was faced with the necessity for tabulating and analyzing the records in which special mathematical processes rapidly assumed a position of importance. Concurrently with this evolution of the actuary's technique with respect to life insurance, it is particularly significant to note that the first formal recognition in Great Britain of the profession of actuary is to be found in an Act of Parliament, passed as early as 1819, providing that the tables, and the rules, of all death and sickness "benefit societies" should be approved by an "actuary." The methods of calculation, and the formulation of the rules, in respect both of life insurance and sickness benefits, have thus for many years been primarily the actuary's responsibility. Comparable methods have naturally been developed in connection also with the other contingencies of human life, in addition to sickness and death—namely, birth, marriage, accident, disability, and unemployment —so that today the actuary may be described as the professional man whose duty it is to deal with all the statistical, mathematical, and financial calculations which form the basis of any schemes involving the contingencies of human life.

Remembering the definition of "insurance," and these essential responsibilities of the actuary, it is abundantly obvious that any form of health insurance is a type of insurance with which the actuary, if he is to discharge his full duties, must be immediately and directly concerned. Health insurance, whether it is to give benefits in cash or benefits in kind, and whether it is instituted through voluntary action, or enforced partially or wholly by governmental compulsion, is therefore clearly a type of insurance which can be—and I do not hesitate to say, should be—set upon a framework complying with the well known and well tried principles and methods which have been developed by those fully qualified actuaries who have been trained both in the theoretical requirements and in the school of practical experience.

If official confirmation of this view should be required, it is to be found in detail in the Year Book of the Institute of Actuaries of Great Britain, where clearly defined responsibilities of precisely this character are placed upon the actuary by a wide variety of Acts of Parliament, and in Canada, for example, in the Memorandum issued by the Superintendent of Insurance (of the Dominion Department of Insurance) respecting actuarial valuations of fraternal benefit societies—which, it is to be noted, generally provide benefits during sickness, sometimes in cash and sometimes in kind, based on principles very similar to those involved in governmental "health insurance" schemes.

There would not seem to be any good reason for legislative apathy concerning the actuarial aspects of governmental schemes, when the legislatures have so insistently and properly demanded actuarial supervision of voluntary plans. It would appear that sound principles of government finance should require that a government's financial adventures ought to be regarded in the same manner, and regulated by the same types of prudent supervision, as those which quite properly are imposed on voluntary forms of business. I use the word "adventures" in no invidious sense —for all our economic and financial efforts, whether undertaken by individuals, or by some voluntary collection of individuals, or by that all-inclusive collective known as "government," must always be in reality "adventures"—expeditions into the partially unknown—a realm to be explored, intelligently, cautiously, without recklessness, and always, if at all possible, with an ever open road for orderly and dignified retreat. It is precisely through neglecting these cautionary restrictions in many fields of activity—politically nationalized railroads, free old age pensions instituted with almost no financial investigation, governmental pensions sold at inadequate rates (often to the rich, though originally intended for those with only moderate incomes), insufficiently controlled unemployment relief, and governmental subsidies to all and sundry—that we have, even in this greatly favoured country, reared an edifice of governmental debt of a dangerously top-heavy character, with all the resultant and growing sectionalisms so threatening to our national unity.

Since, therefore, as I see the problem, the actuary must have an unavoidable responsibility in the establishment of health insurance, let us examine in some detail what those duties ought to be, and are:

In the first place, the scales of benefits which are to be given by the plan must be settled, and the conditions under which they will become payable must be drawn. When those scales of benefits, and conditions for payment, are definitely known —but not until they are definitely known—no person but a qualified actuary has at his command either the technical mathematical-statistical knowledge, or the practical administrative experience, necessary for the calculation and prescription of the financial contributions which will be essential for their support.

Alternatively, of course, in some instances it may be thought desirable to set, first of all, the scale of contributions, and for the actuary thence to determine the benefits which they may be expected to provide.

In either case the two considerations of paramount importance are:

Firstly, that a proper relationship, founded upon actuarial principles and calculations, must be established between the scales and conditions of benefits on the one hand, and the contributions on the other hand, and,

Secondly, that the scales and prescribed provisions for payment both of contributions and of benefits must be specifically defined. Only under such circumstances can the actuary make his calculations, and give a certificate that the plan is "actuarially sound."

A certificate of "actuarial soundness" — or "actuarial solvency," to use an alternative and equivalent term — therefore requires that the certifying actuary has satisfied himself, after complete investigation of all the relevant circumstances determining the conditions for payment of contributions, benefits, and all other possible expenditures, that the financial basis and control of the entire scheme is so constructed that "in his opinion . . . the reserve shown by (his) valuation, together with the . . . contributions to be thereafter received from the members according to the scale in force at the date of valuation, is sufficient to provide for the payment at maturity of all the obligations of the fund without deduction or abatement." That phraseology, as an example, is the official requirement with which a certifying actuary must conform in reporting on the state of a fraternal society in Canada. That certifying actuary, moreover, by general legislative prescription throughout Great Britain, and in Canada, must, of course, be fully qualified, that is to say, he must (except where special circumstances justify the supervising authorities in allowing some other person to perform the work) be a Fellow of one of the four recognized bodies—the Institute of Actuaries of Great Britain, the Faculty of Actuaries in Scotland, the Actuarial Society of America, or the American Institute of Actuaries. Clearly an Associate only of one of those bodies cannot generally be admitted as a qualified certifying officer, seeing that the examinations for Associateship cover only the less practical first portion of the training, and at the Actuarial Society and the American Institute on this Continent do not include the technique or valuation of, or any but the most superficial acquaintance with, health insurance in any of its forms.

"Actuarial soundness," accordingly, can be claimed for any plan only when all of the following conditions are fulfilled:

(1) The benefits offered by the plan must be defined, and the conditions for their payment must be clear.

(2) The corresponding contributions, or other financial arrangements, by which the costs of such prescribed benefits are to be met, must be determined by proper actuarial calculation, as previously described.

(3) Any power to alter the basis, terms, or conditions of the scheme must be subject to an actuarial certificate that the costs of such alteration are within the financial capacity of the plan, and

(4) Adequate machinery must exist for the certification, inspection, and control of claims for benefits, in order to make certain that they fall within the terms and conditions of the scheme, and for the impartial and judicial interpretation of the numerous and difficult administrative problems which inevitably arise.

If any plan of insurance cannot meet these tests, it cannot be certified as being "actuarially sound." It must then obviously be classed as being either "actuarially indeterminate," or "actuarially unsound." If the actuary cannot set out the benefits, conditions, contributions, powers of alteration, and methods of organization and control in such a distinct manner that he can, according to his best judgment and experience, formulate his methods of calculation with reasonable certainty and with adequate (though not, of course, excessive) margins of safety, then it is obvious that the basis of the plan must be "actuarially indeterminate" — "void for uncertainty," as I believe the lawyers would say. If, on the other hand, a plan is definable enough, but shows itself, on actuarial calculation, to propose benefits greater than the contributions can support, then there is no alternative to its being reported as "actuarially unsound."

WHAT, FOR INSTANCE, IS THE ACTUARIAL BASIS OF THE BRITISH COLUMBIA HEALTH INSURANCE ACT?

I have dealt at some length with this matter because, having in 1935 been retained to report to the Hon. G. M. Weir, Provincial Secretary, on the cash benefit provisions then included in the British Columbia Health Insurance Bill, and having estimated the probable incidence of claims thereunder without any necessity arising in that report for a certification of "actuarial soundness" of the whole Bill, I have since been named in some quarters as a fully qualified actuary who has examined the entire scheme without having questioned it, in others as an actuary who has definitely

opposed it, while again I have been challenged to state specifically that the scheme is not "actuarially sound." In view of a great many quite erroneous interpretations of my position which have thus been circulated, I think it is only proper that I should repeat here the opinion which I have previously expressed, and which I hope may now be understood in view of the preceding definitions. It is this:

The Act, as finally passed, calls for employees' contributions of 2% of wages up to $1800 per annum, but varying from 35c weekly (reducible, however, by the Commission) up to 70c weekly, and employers' contributions of 1% but varying between 20c weekly (again reducible by the Commission) and 35c weekly—that is to say, it calls for contributions lying somewhere between a minimum of 55c weekly, or less, and a maximum of $1.05 per week. The benefits to be given, however, are not at all clearly ascertainable in advance. They are stated at first to be:

(a) Physician's services (including pre-natal and maternity treatment, and surgical and specialist services).

(b) Public-ward hospitalization (including all services which the hospital is equipped to provide).

(c) Drugs, medicines, and dressings (of which possibly one-half may be payable by the insured).

(d) Laboratory, X-ray, biochemical, and other services.

It is, however, to be noted very specially that the following extremely important conditions are attached, either by specific statements in other portions of the Act or by obvious implication:

(1) The hospitalization benefit is limited to ten weeks, but may be extended by regulations.

(2) Additional benefits may be provided by the Commission to the extent that the resources of the fund permit.

(3) Any or all of the benefits may be limited by the Commission.

(4) No benefits can be obtained during a first qualifying period of 4 weeks; thereafter they shall be obtainable so long as the contributions are payable and for 4 more weeks and also for such additional period as may be determined by the Commission; if the employee falls ill and is unable to work he (but not his dependents) may receive benefits for 12 more weeks, or for a longer period if prescribed by the regulations; and the right to benefits can be re-established after eligibility ceases, at the end of a re-qualifying period of one week, after which benefits are obtainable while contributions are payable and for one more week and also for such additional period as may be determined by the Commission.

(5) The physicians are to be remunerated, at a rate not less than $4.50 per person per annum, by salary, per capita, or fee system, as may be fixed and determined by the Commission's regulations; the scales of payment to all others—pharmacists, hospitals, laboratories, etc.—shall be fixed and determined by the Commission's regulations; and in all cases the Commission can penalize any physician, pharmacist, manager of hospital or laboratory, or any other person who fails to provide services according to the standards prescribed by the Commission, and,

(6) The Commission (of five members)—who may, but need not, be advised by a Technical Advisory Council—is clothed with such exceedingly wide powers that it is, I believe, essential that very careful examination (to which I shall return) should be given by everyone concerned to their inevitable meaning and effect.

It will be seen at once that the benefits to be offered in return for the contributions are, in reality, almost wholly undefined. It is also to be noted especially that the Commission has almost absolute power to state which of the listed benefits shall be granted, whether they shall be provided at the suggested or at a lower or higher scale, for how long they shall be receivable, what the rates of payment shall be for every one of the necessary services, and how, when, and where every single function under the Act shall be performed. Under such circumstances it is manifestly impossible to set out, with any approach to definiteness, either what the benefits are likely to be, or what they are likely to cost.

The plan consequently means nothing more than that the employees and employers are to be required to pay over to the Commission certain widely varying sums, which the Commission can disburse in almost any manner whatsoever that it may choose. No relationship is stated between any of the possible amounts of contributions and any of the innumerable scales of benefits which the Commission might adopt.

In my opinion, therefore, it is impossible to certify the scheme as being "actuarially sound." It is likewise impossible to certify it as being "actuarially unsound." An actuarial basis simply does not exist—for the possible limits of variation are so wide that no reasonable estimates of probable future experience can be made. The scheme in its present form, accordingly, can only be held to be "actuarially indeterminate."

This situation, I believe, is made even more serious by the extraordinary powers vested in the Commission, to which I have already referred—for those powers render the financial implications of the plan even more unmeasurable. Subject only in certain cases—not in all cases—to the approval of the Lieutenant-Governor in Council, the Commission is to be almost entirely a law unto itself, backed by severe punitive powers, against which the citizen is apparently to have no right of appeal. The following provisions of the Act are extremely enlightening in this connection:

(1) The Commission, of five, can function perfectly so long as it can muster a quorum of only two of its members.

(2) Even if the suggested "Technical Advisory Council" should be appointed—and its establishment is not obligatory—the Commission can ignore its advice completely.

(3) The Commission may "penalize any person . . . who fails to provide services according to the standards prescribed by the Commission . . . by debarring him . . . from all rights of serving or of providing benefits . . . under this Act."

(4) "The Commission shall have the like powers as the Supreme Court for compelling the attendance of witnesses and of examining them under oath," etc.

(5) "The Commission shall have exclusive jurisdiction to inquire into, hear, and determine all matters and questions of fact and law arising under this Act, and no proceedings by or before the Commission shall be restrained by injunction, prohibition, or other process or proceeding in any court, or be removable by certiorari or otherwise into any court."

(6) "The Commission shall have full discretionary power at any time to re-open, re-hear, and re-determine any matter which has been dealt with by it."

(7) Every person is to become subject to a fine up to $500 who even "neglects to perform or observe any duty or obligation imposed on him" by the Act; the Commission may by regulation itself prescribe fines up to $50; and the Commission may impose upon any monetary defaulter "such a percentage upon the sum in default as may be prescribed by the Commission"; and lastly,

(8) "Where default is made by any employer or person in the payment . . . of any sum of money . . . the Commission may issue its certificate stating the sum so required to be paid . . . and such certificate, or a copy of it . . . may be filed with the Registrar of the Supreme or any County Court, and when so filed shall become an order of that Court and may be enforced as a judgment of the Court."

It would seem that the implications of these provisions should be realized more widely than appears to be the case.

THE APPROACH TO A CONSTRUCTIVE POLICY

I have dealt with the preceding matters at some length because they obviously fall within the title of this address since they influence directly the financial arrangements and obligations implied by any such scheme of compulsory health insurance. Some of these observations, admittedly, are open criticisms. I sincerely trust, however, that you will understand that they are not meant to be merely destructive. Criticism, whenever possible, should be constructive. I should therefore like to submit the following suggestions, which, I believe, in the light of the experiences of other similar plans both in Canada and elsewhere, should form the basis of any attempt to establish a scheme of compulsory health insurance, and which might well lead to its successful operation.

(1) The plan ought not to be conceived as a punitive measure, predicated on the supposition —as I have heard it stated—that the medical profession and all its ancillary services are now organized on a wrong foundation, which must be compelled to undergo improvement by being brought under the rule of a wholly non-medical Government Commission. The basis of approach should preferably be to recognize the devotion and sincerity of those who take the Hippocratic oath, and who so often give almost every moment of their lives in their attendance on the sick, whether rich or poor.

(2) As the very first step, the plan should reach a clear and honorable agreement with all those indispensable groups—doctors, nurses, druggists, hospital officials, and laboratory technicians —without whose co-operation any such plan must be foredoomed to failure.

(3) Adequate provisions should be included for administrative control by a non-political Commission of practical and fully qualified men, thoroughly experienced in medicine, insurance administration and claim supervision, and finance. An "Advisory Council," moreover, should be mandatory, and should function in such a manner (as in the cases of the Advisory Committees under the British and the 1935 Canadian unemployment insurance schemes) that its recommendations cannot be ignored.

(4) Definite provisions should be included for the refereeing of disputed claims and controversial and administrative questions, with adequate machinery for the judicial determination of all such matters, and for appeals, so that no single body, whether political or non-political, should have any opportunity for the exercise of arbitrary powers.

(5) Provision should be made for proper certification, by a fully qualified actuary, of the original scales of contributions and benefits, which should be specifically stated, and also for the certification of any changes in those stated benefit and contribution scales, so that every financial adjustment of the plan should be explored adequately and reported on publicly prior to its adoption, to the end that the beneficiary may have some reasonably close idea of the benefits which he may expect to receive, and employers and employees may know how their funds are to be used.

THE PLACE OF "HEALTH INSURANCE" IN CO-ORDINATED "HEALTH SERVICES"

If the problem could be approached carefully along these lines, with all the emphasis upon the rights both of the persons to be insured and those who would be called upon to provide the services, and also with the most complete elimination possible of every political influence and opportunity for arbitrary control, then it might well be that the present organization of the "medical services"

—using that term in its widest sense—could be rendered more effective. But, in order to attain any such objective, I should like again to direct your attention to the fact that the usual types of government-sponsored "health insurance" fail entirely to reach several of the most important basic aspects of the real problem which is involved.

It is important to remember that these governmental "health insurance" plans are essentially an attempt to provide medical services through a system of regularized payments in advance. But they do so only for a special group of persons, and then only during a certain period of their lives; they leave out of consideration entirely not only all the rest of the community, but even the special group itself almost immediately the insured person ceases to stand in the particular relationship to some "employer" of being an "employee" of an arbitrarily specified earning power, or that employee's dependent. What is there, moreover, in the figure of $1800 per annum, which calls for the provision of a government-regulated medical service for those earning up to that amount, while the person earning $1801 per annum or more, or not earning anything at all, is to be excluded?

All these plans, of course, are in reality attempts to improve the conditions under which medical services shall be available. But I think it may be asked, most appropriately, whether they do not begin at the wrong end of the problem. The fact that I have explained "actuarial soundness" at some length is not, of course, special pleading in any sense—for the real problem involved is, in my opinion, hardly "actuarial" at all. It is, as I have suggested on a number of previous occasions, essentially a "public health" matter, to be settled according to obvious principles of common sense. I would ask you to recall the manner in which we permit uncontrolled birth, provide only partial health supervision during the school years, and then allow the adult to impair his health in any way he chooses — through misfortune, ignorance, carelessness, or abuse; and then, when people of all classes thus eventually fall ill, the "health insurance" plan suggests that only a special class of them shall be assisted, in respect of certain particular types of illness, and for an arbitrary length of time. Is not that illogical? Does it reflect much credit on our statesmanship? Yet we insist—rightly—upon universal education. Why do we not insist, even more rightly, on *co-ordinated* efforts to attain a better state of *general* health? A healthy but uneducated person—who at the least will probably grow up as one of "Nature's gentlemen," imbibing his knowledge from a contemplation of the wonders and beauties of the Universe—will surely be a sounder, safer, and a better citizen than the unfortunate descendant of a bad heredity, doomed from infancy to bear throughout a miserable life the failings of incompetence and disability. What do I mean by "co-ordinated efforts to attain a better state of general health"? I mean emphasis first of all on intelligent maternity, on health education, on periodical health examinations, on sickness registration, and on proper physical and mental recreation—in short, emphasis on prevention rather than cure—and for *all* the people—not merely for a special group earning up to $1800 per annum or some other arbitrary figure.

I am not intending to suggest, even remotely, any form of "state medicine," under which the physicians and others engaged in the medical services would become merely salaried employees of the state. I do, however, believe that the co-ordination and enlargement of the preventive services, for all the people, could do much more to eliminate illness, to prevent its spread, and to control its ill effects than we have yet realized. "Health insurance"—not necessarily in the stereotyped and limited form which we now generally discuss, and not only, perhaps, for a special group during a limited time—might then be able to deal more advantageously with the residual sickness which the preventive measures had not been able to control. Under such circumstances a "Health insurance" scheme, conforming with sound insurance principles, could take its proper place as an essentially curative agency, at greatly lessened cost. Even if the saving were wholly absorbed by the preventive services which I have suggested, we should in reality be much more prosperous—physically and spiritually — and much more capable of exhibiting any efficiency which we might inherently possess.

Special Articles and Association Notes

The Manitoba Medical Association Review

Formerly the Bulletin of the Manitoba Medical Association

ESTABLISHED 1921

WINNIPEG, FEBRUARY, 1939

Published Monthly by the

MANITOBA MEDICAL ASSOCIATION

Editorial Office

102 MEDICAL ARTS BUILDING, WINNIPEG

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Annual Subscription - $2.00

Editorial or other opinion expressed in this Review is not necessarily sanctioned by the Manitoba Medical Association

Membership in the Manitoba Medical Association

Statements of the annual dues have been sent to members of the Manitoba Medical Association. Application forms have also been forwarded to those who have not been members or whose membership has lapsed. For the convenience of those paying their dues a cheque form is attached and also a stamped and addressed reply envelope. The collection of dues, like other office routine, involves some expenditure of funds and an early response will help to reduce this expense.

Those who are to be away or for any other reason do not wish to join the Manitoba Medical Association this year are asked to co-operate by filling out the "Alternative Reply Form" and returning it in the envelope provided. This will avoid the forwarding of another statement.

The Executive Committee have attempted to make the payment of the annual dues as convenient as possible for the members, and ask for the co-operation of the profession.

ANNUAL MEETING

Visiting Speakers

The Canadian Medical Association are arranging for two speakers, in addition to the President and the General Secretary, to attend the Annual Meeting of the Manitoba Medical Association in September. The names of the visitors will be announced at an early date.

Scientific Programme

Members of the Manitoba Medical Association are invited to submit papers for the scientific programme of the annual meeting in September, 1939. Those wishing to deliver papers should forward copies or an abstract. Applications will be received up to May 1st. The selection will be made by the Scientific Programme Committee.

Suggestions from members as to particular subjects which they would wish to have discussed are also invited.

Communications may be sent to the Honorary Secretary, Manitoba Medical Association, 102 Medical Arts Building, Winnipeg. They will be sent on to the Committee for consideration and action.

FACULTY OF MEDICINE

University of Manitoba

Post Graduate Course in Paediatrics

February 14, 15 and 16, 1939

All clinics will be held at the Children's Hospital, except that from 11.00 to 12.00 on the first day, which will be on East 1 at the General Hospital.

All the sessions of this course will be illustrated by clinical cases.

The Children's Hospital is located on Main Street at Aberdeen Avenue, one block south of Redwood Avenue.

The visiting clinician will be Dr. Joseph Brennemann, Chief of Staff of the Children's Memorial Hospital, Chicago, and Professor of Pediatrics at the University of Chicago. He is editor of a well known system of pediatrics. As well as reading two papers Dr. Brennemann will take part in the discussion of the clinical presentations during the first two days. The Committee believe that in Dr. Brennemann they have obtained the assistance of the best man available to help in the problems of practice.

FIRST DAY

TUESDAY, FEBRUARY 14

9.00-10.00 a.m.—Registration at the Medical College.

10.00-10.15 a.m.—Welcome by Dean of the Medical College.

10.15-11.00 a.m.—Address by Dr. Joseph Brennemann, Chief of Staff, Children's Memorial Hospital, Chicago.
Random Thoughts on the Practice of Medicine.
This lecture will be given in Theatre "A" of the Medical College.

11.00-12.00 a.m.—Clinic, Rheumatic Disease in Children. Dr. J. M. McEachern, East 1, General Hospital.

12.30- 1.30 p.m.—Luncheon, General Hospital.

AFTERNOON CLINICS AT CHILDREN'S HOSPITAL

2.00- 3.00 p.m.—Treatment of the Pareses and Paralyses following Poliomyelitis. Dr. A. E. Deacon.

3.00- 4.00 p.m.—Treatment of Infantile Diarrhoea. Dr. H. E. Popham.

4.00 p.m.—Demonstration of cases in wards.

8.15 p.m.—Address by Dr. Joseph Brennemann before the Winnipeg Medical Society, to be given in the Physiology Theatre, Medical College. Subject: The Acute Abdomen in the Child.

SECOND DAY

WEDNESDAY, FEBRUARY 15

All Clinics at the Children's Hospital

9.00-10.30 a.m.—Chronic Cough in Children: A Group Symposium.

Introduction by the Chairman.

Allergy as a Cause. Dr. Gordon Chown.

Chronic Pulmonary Infection as a Cause. Dr. Harry Medovy.

Sinusitis as a Cause. Dr. F. A. Macneil.

10.30-11.00 a.m.—Demonstration of methods of testing for Allergy. Dr. C. H. A. Walton.

11.00-12.00 a.m.—On Squint. Dr. J. A. McGillivray.

12.30- 1.30 p.m.—Luncheon at the Children's Hospital.

There will be an exhibit of X-ray films which Dr. Patriarche will be glad to demonstrate before and after the luncheon.

1.30- 2.15 p.m.—Treatment of Diabetes in Children. Dr. Harry Medovy.

2.15- 3.00 p.m.—X-ray Interpretation in Diseases of the Long Bones in Children. Dr. E. Patriarche.

3.15- 4.00 p.m.—Newer Aspects of Tetany. Dr. Bruce Chown.

4.30- 6.30 p.m.—Reception at the home of Dr. and Mrs. Gordon Chown, 588 Broadway.

THIRD DAY

THURSDAY, FEBRUARY 16

All Clinics at the Children's Hospital

9.00- 9.45 a.m.—Treatment of Empyema. Dr. J. D. McEachern.

10.00-10.45 a.m.—Infantile Eczema. Dr. A. R. Birt.

11.00-11.45 a.m.—Some Classical Feeding Difficulties. Dr. O. J. Day.

12.00- 1.00 p.m.—Luncheon at Children's Hospital.

1.00- 1.45 p.m.—Anaemia in Infants and Children. Dr. J. N. Crawford.

2.00- 2.45 p.m.—Otitis Media and Mastoiditis in Children. Dr. I. H. Beckman.

3.00- 3.45 p.m.—Hypothyroidism in Children. Dr. G. Shapera.

3.45 p.m.—Demonstration of cases in wards.

Department of Health and Public Welfare

NEWS ITEMS

"RHEUMATIC FEVER: CHILDHOOD RHEUMATISM"

The following article on "Rheumatic Fever: Childhood Rheumatism" by Dr. May G. Wilson, Assistant Professor, Department of Pediatrics, Council University Medical College, was recently published in "Preventive Medicine" by the New York Academy of Medicine:

"Rheumatic fever owes its place as one of the most important diseases of childhood to the fact that the heart is probably always involved. Published mortality statistics for New York City reveal that rheumatic fever ranks highest as the cause of death for girls, and is second only to accidental deaths for boys. It has been estimated that 80 per cent. of adult heart disease in persons under the age of forty is of rheumatic etiology, usually acquired in childhood, and that about one per cent. of children of school age have rheumatic heart disease. Rheumatic fever is not a reportable disease, and, therefore, its actual incidence in the population is not known. The disease is more prevalent in cities of the north temperate zone where it exhibits a definite seasonal trend. In New York City the highest incidence has been observed in the early winter and spring months, with a corresponding lowered incidence in the summer months. It appears more frequently among under-privileged children, although it is observed in families of the well-to-do. There is no demonstrable racial predilection.

"It has long been recognized that the disease tends to be concentrated in certain families. Recent genetic studies of rheumatic families indicate that there may be an hereditary factor distributed among the population which makes the bearer susceptible to rheumatic fever. This factor is transmitted as a single autosomal recessive gene. The exact role of environment and contagion in the acquisition of the disease by susceptible individuals is still undetermined.

"Although the causative agent is as yet unknown, rheumatic fever is generally believed to be an infection. Its relation to other infections, particularly those of the respiratory system, is still a matter of controversy. Attempts to isolate a specific micro-organism or to transmit the disease to animals, have been unsuccessful up to the present time. Evidence has been presented recently which, if confirmed, would indicate that rheumatic fever may be due to a virus, acting alone or in association with other organisms.

"Rheumatic fever is essentially a disease of childhood, having its onset and more characteristic manifestations during this period. The usual age of onset of childhood rheumatism is in the pre-school period—at about the average age of six years. It is generally recognized that the tendency to occurrence and recurrence of the disease diminishes after puberty.

"Recent pathological studies have demonstrated the widespread distribution of vascular lesions, affecting not only the cardiac structures and peripheral vessels, but minute arteries, capillaries and veins. The selective action on connective tissues, serous membranes and vascular structures is notable in the symptomatology of childhood rheumatism.

MANIFESTATIONS OF CHILDHOOD RHEUMATISM

"Childhood rheumatism is essentially different in its symptomatology and course from the adult type of the disease. Clinical and pathological studies have revealed that the heart is usually damaged from the onset of rheumatic infection. In addition, there is concurrent and successive involvement of different tissues and structures of the body to a varying degree. Symptoms which are easily detectable often dominate the clinical picture, while symptoms and signs of cardiac involvement are more often subclinical and may escape recognition. This has led to the erroneous conception, or loose terminology, that tonsillitis, chorea or polyarthritis 'induce, result in, or are complicated by rheumatic heart disease.' These associated manifestations of rheumatic infection have been used as a measure of the severity of the infection in terms of 'resulting heart disease.' It is evident, however, that the degree of cardiac involvement in this disease is the more accurate index of the severity of the infection, and not the presence or absence of any of the other associated manifestations.

"The onset of rheumatic fever is usually characterized by general symptoms of infection: fever, leukocytosis, increased sedimentation rate, anemia, loss of weight and fatigability; symptoms which are not peculiar to rheumatic fever but which may be present in any of the acute and chronic infections of childhood, such as sinusitis, childhood type of tuberculosis, undulant fever and blood dyscrasias. A diagnosis of rheumatic disease can usually be made in the presence of signs of involvement of: the cardiac structures—subacute and acute carditis; the peripheral vessels, arterioles and capillaries—cutaneous manifestations, abdominal pain and chorea; the connective tissues—growing pains, joint pains, polyarthritis and subcutaneous nodules. These signs and symptoms, with the exception of carditis, and, possibly, of rheumatic nodules, are not in themselves pathognomonic of rheumatic fever and may be present in other infections. The onset of rheumatic fever may be ushered in by any or all of the protean manifestations of the disease. In children the usual course of the disease is characterized by recurrences of any of the manifestations, in successive years or after varying numbers of years of freedom from symptoms. Acute and subacute carditis is unrecognized in the majority of children who are later found to have rheumatic heart disease. The extent of cardiac damage in these children is usually far less than in those who have exhibited recognizable signs and symptoms of active carditis. During the intervals when children with rheumatic heart disease are free from symptoms of rheumatic infection, they are able to carry on their normal activity without any circulatory symptoms. The physical signs of cardio-valvular disease regress in a large percentage of these children.

PREVENTION AND CONTROL OF CHILDHOOD RHEUMATISM

"It is evident from this brief summary of our knowledge of the natural history of rheumatic fever that specific measures are not as yet available for the prevention and control of this disease. There is, however, some evidence which would indicate that certain general measures may be of value.

"The concept that an hereditary susceptibility underlies the familial tendency of rheumatic fever, would indicate that eugenic principles may have a practical application in this disease.

"The strikingly lower incidence of rheumatic fever in children of the well-to-do, living in New York City within a few blocks of the tenement districts from which our clinic children are drawn, would indicate that unfavorable environmental conditions may play a contributing role in its prevalence among the poor. Provision of decent housing would eliminate over-crowding

and furnish adequate plumbing, heating and ventilation. Improvement in economic status would provide sufficient warm clothing to reduce the chance of chilling, and adequate food for the maintenance of proper nutrition. The eventual establishment of these preventive measures is a goal to strive for in the broad field of public health.

"The increased incidence of the disease in the early winter and spring months and its lowered incidence in the summer months in New York City indicate that the avoidance of exposure to inclement weather by susceptible children during the seasons when the disease is prevalent, is essential. Such a program would require the active co-operation of the school authorities to arrange for intermittent school attendance. The reported low incidence of rheumatic fever in tropical and sub-tropical localities would indicate that continued residence of susceptible children in sections of the country where the climate is equable, might prove beneficial. However, there is as yet no conclusive evidence to support this notion.

"These suggested preventive measures should be directed particularly toward the children of families of known rheumatic background. The regime which has been found valuable in the management of the pre-tuberculous child may equally well be applied to the hereditarily 'susceptible' rheumatic child. The prevention of intercurrent infections and over fatigue are of great importance.

"These measures for the prevention of the disease should be equally valuable in the prevention of recurrences of rheumatic relapses. There is no conclusive evidence to support the use of any 'specific' therapeutic measure, such as tonsillectomy sera, vaccines or drugs, in childhood rheumatism. At the onset of symptoms of rheumatic infection and throughout the entire course, adequate bed rest and intelligent nursing care are essential. The treatment is mainly symptomatic. The medication usually comprises anti-pyretic drugs and sedation. The symptoms of congestive failure may necessitate the use of digitalis and diuretics. A sufficiently prolonged period of convalescent care is of the utmost importance. This is best given in institutions properly equipped for the care of such patients. The variability in duration of the manifectations of activity in any one child indicates that the disease is self limited. Termination of the convalescent period with return to normal activity is permissible only following subsidence of signs and symptoms of active infection. This is frequently indicated by progressive gain in weight and a normal reaction to ordinary activity.

"Until the cause of the disease is known and more accurate information as to its incidence is available, our efforts to prevent and control rheumatic fever should be directed toward the objective of improving the environmental conditions of children of rheumatic families. Proper hygiene, adequate food, sufficient clothing, avoidance of over fatigue and intercurrent infections, should be reflected in a diminished incidence of rheumatic fever among children of that social class in which the disease appears to be most prevalent."

COMMUNICABLE DISEASES REPORTED

Urban and Rural — December, 1938.

Occurring in the Municipalities of:

Whooping Cough: Total 178—Woodworth 100, Winnipeg 12, Rivers 9, Kildonan East 6, Brandon 2, Daly 2, St. Boniface 2, Argyle 1, St. James 1, Unorganized 1 (Late Reported: September, Unorganized 2; October, Unorganized 18; November, Unorganized 21, Ste. Rose 1).

Scarlet Fever: Total 124—Winnipeg 58, Unorganized 7, Brandon 6, Miniota 5, Portage Rural 5, Rivers 5, St. Andrews 5, Woodworth 5, Cameron 4, Pembina 4, Transcona 3, Blanshard 2, Kildonan East 2, Portage City 2, Brooklands 1, Daly 1, Lac du Bonnet 1, Louise 1, Morton 1, Rockwood 1, Roland 1, Shell River 1, Siglunes 1, St. Boniface 1, St. Vital 1.

Measles: Total 117—Lorne 35, Argyle 16, Victoria 15, Franklin 10, Winnipeg 3, Oakland 8, Brandon 4, Roblin Rural 4, Turtle Mountain 2, Brokenhead 1, Cypress South 1, Daly 1, Kildonan West 1, Morden 1, Norfolk North 1, Riverside 1, Strathcona 1 (Late Reported: November, Lorne 12).

Chickenpox: Total 113—Winnipeg 16, Dauphin Town 16, Kildonan West 16, Unorganized Territory 15, Transcona 9, Blanshard 7, Flin Flon 4, Morris Rural 3, St. Boniface 3, St. Francois 2, Arthur 1, Brandon 1, Melita 1, Portage City 1, Roblin Rural 1, Rockwood 1, Shell River 1, St. Andrews 1, St. Clements 1, St. James 1 (Late Reported: August, Kildonan West 2; November, St. Clements 8, Kildonan West 1, Unorganized 1).

Mumps: Total 100—Winnipeg 67, St. James 21, Kildonan East 9, Unorganized 2, Riverside 1.

Diphtheria: Total 30—Winnipeg 13, Flin Flon 10, Unorganized Territory 3, Hanover 2, Norfolk North 1, St. Andrews 1.

German Measles: Total 12—(Late Reported: November, Unorganized 12).

Erysipelas: Total 9—Winnipeg 5, Brooklands 1, La Broquerie 1, St. James 1, St. Vital 1.

Smallpox: Total 8—Swan River Rural 6, St. Francois 2.

Tuberculosis: Total 8—Winnipeg 7, Boulton 1.

Septic Sore Throat: Total 6—Woodlea 5, Rossburn Rural 1.

Anterior Poliomyelitis: Total 5—St. Laurent 1 (Late Reported: November, Brokenhead 2, St. Vital 2).

Influenza: Total 5—(Late Reported: November, Blanshard 1, Grandview Rural 1, Portage Rural 1, Ritchot 1, Ste. Anne 1).

Diphtheria Carrier: Total 5—Unorganized 2, Cartier 1, Flin Flon 1 (Late Reported: November, Unorganized 1).

Typhoid Fever: Total 3—Hanover 2, Dufferin 1.

Cerebrospinal Meningitis: Total 2—Dufferin 1 (Late Reported: November, Grey 1).

Typhoid Paratyphoid A.: Total 2—Franklin 1, Unorganized 1.

Venereal Disease: Total 131—Gonorrhoea 57, Syphilis 74.

DEATHS FROM ALL CAUSES IN MANITOBA

For the Month of November, 1938

URBAN—Cancer 34, Pneumonia 12, Syphilis 4, Tuberculosis 4, Diphtheria 3, Influenza 2, Cerebrospinal Meningitis 1, Typhoid Fever 1, Septic Throat 1, Whooping Cough 1, all others under one year 14, all other causes 165, Stillbirths 12. Total 254.

RURAL—Cancer 37, Pneumonia 22, Tuberculosis 20, Influenza 6, Whooping Cough 4, Diphtheria 2, Scarlet Fever 1, Typhoid Fever 1, all others under one year 28, all other causes 155, Stillbirths 18. Total 294.

INDIANS—Tuberculosis 7, Pneumonia 5, all others under one year 5, all other causes 2, Stillbirths 1. Total 20.

Medical Library University of Manitoba

Current Medical Literature

"The British Medical Journal"—December 24, 1938

"Modern Views in the Prevention of Tuberculosis"—by D. M. Dunlop, M.D., F.R.C.P. (Ed.), Physician Royal Infirmary, Edinburgh.

"Four Cases of Weil's Disease Infected from the Same Stream"—by Kenneth M. Robertson, M.D. M.R.C.P., Honorary Physician, Royal Hampshire County Hospital, Winchester.

"Mastoid Operations—A Further Study"—by Walter Howarth, M.A., M.B., F.R.C.S., Surgeon to the Ear, Nose and Throat Department, St. Thomas's Hospital, and Geoffrey Bateman, B.M., F.R.C.S. Chief Assistant to the Department.

"Association of Stammering and The Allergic Diatheses"—by A. M. Kennedy, M.D., F.R.C.P. Professor of Medicine in the University of Wales and Director of the Medical Unit, School of Medicine, Cardiff, and D. A. Williams, B.Sc., M.D. Deputy Medical Superintendent, Llandough Hospital, Cardiff; Late Assistant in the Medical Unit School of Medicine, Cardiff.

"Three Cases of Intussusception in the Adult—With Reference to Aetiology"—by C. L. Heanley F.R.C.S., M.R.C.P., Surgical First Assistant and Surgical Registrar, London Hospital.

"Congenital Deformities of Legs"—by Reginald Broomhead, M.B., Ch.B., F.R.C.S., Honorary Surgeon Orthopaedic Department, General Infirmary Leeds; Lecturer in Orthopaedics, University of Leeds.

"Edinburgh Medical Journal"—November, 1938.

"Traumatic Meningeal Haemorrhage, with a Review of Seventy-one Cases"—By J. Hogarth Pringle F.R.C.S. (Eng.), Glasgow.

"Harvey in Scotland"—by Henry Wade, C.M.G. D.S.O., F.R.C.S. (Ed.).

"Results of Recent Studies on Anterior Pituitary Hormones"—by J. B. Collip, from the Department of Biochemistry, McGill University, Montreal, Can

Clinical Recollections and Reflections — XXVII "Lister and His Contemporaries in Edinburgh"—by C. E. Douglas, M.D., LL.D., F.R.C.S. (Ed.).

"Isolation of the Bacillus Tuberculosis from Sputum Comparison of the Antiformin and Sulphuric Acid Methods"—by A. Saenz and J. T. Paterson, from the Institut Pasteur, Paris.

"The Practitioner"—January, 1939.

"The Importance of Diet and General Treatment in Dermatology"—by H. W. Barber, M.B., B.Ch. F.R.C.P., Physician in Charge of the Skin Department, Guy's Hospital, London.

"Psychological Factors in Skin Diseases"—by C. H. Rogerson, M.D., M.R.C.P., D.P.M., Medical Director, Cassel Hospital for Functional Nervous Disorders, Penshurst.

"Significance and Treatment of Itching"—by W. N. Goldsmith, M.A., M.D., F.R.C.P., Assistant Physician to the Skin Department, University College Hospital; Physician, St. John's Hospital for Diseases of the Skin; Physician for Disease of the Skin, the West End Hospital for Nervous Diseases.

"Pyogenic Infections of the Skin"—by G. H. Percival, M.D., Ph.D., F.R.C.P. (Ed.), D.P.H., Physician to the Skin Department, Royal Infirmary, Edinburgh; Lecturer in Diseases of the Skin, University of Edinburgh; Dermatologist to the Edinburgh Corporation.

"The Diagnosis and Treatment of Common New Growths of the Skin"—by Sydney Thomson, M.A., M.D., F.R.C.P., F.R.S. (Ed.), Physician in Charge of the Skin Department, King's College Hospital, London.

"The Modern Treatment of Eczema"—by F. F. Hellier, M.A., M.D., M.R.C.P., Honorary Assistant Physician to the Skin Department, The General Infirmary, Leeds.

"Alopecia"—by J. E. M. Wigley, M.B., F.R.C.P., Physician for Diseases of the Skin, Charing Cross Hospital; Physician, St. John's Hospital for Diseases of the Skin; Dean, the London School of Dermatology; Consulting Dermatologist to the London County Council.

"Fear"—by J. R. Rees, M.D., M.R.C.P., Medical Director, the Tavistock Clinic, London.

"First Aid in Air Raids"—by C. Hope Carlton, M.C., M.Ch., F.R.C.S., Surgeon, Seamen's Hospital (Royal Albert Dock) and the South Eastern Hospital for Children; Assistant Surgeon, National Temperance Hospital; Consulting Surgeon, Bexley Cottage Hospital; Brevet-Colonel R.A.-M.C., T.A., Commanding Medical Unit, University of London Officers' Training Corps.

"Diet in Health and Disease XIX.—General Principles of Diet in Childhood"—by B. Rivet, B.A., Dietitian, The Hospital for Sick Children, Great Ormond Street, London.

"The Clinical Journal"—December, 1938

"Puerperal Sepsis"—by Leslie Williams, M.D., M.S., Lond., F.R.C.S., F.C.O.G., Obstetric Surgeon for Out-Patients, St. Mary's Hospital; Surgeon for In-Patients, Queen Charlotte's Hospital.

"Cancer of the Lung"—by Robin Pilcher, M.S., F.R.C.S., M.R.C.P., Professor of Surgery in the University of London; Director of the Surgical Unit, University College Hospital.

"Endeometriosis"—by James Phillips, F.R.C.S. (Ed.), Consulting Surgeon, Royal Infirmary, Bradford.

"Diseases of the Conjunctiva and Cornea in Childhood"—by J. H. Doggart, M.C., F.R.C.S., Ophthalmic Surgeon, Hospital for Sick Children, Great Ormond Street; Assistant Surgeon, Moorfields Eye Hospital.

"Some Anaesthetic Emergencies"—by C. W. Morris, O.B.E., M.B., B.S., M.R.C.S., D.A., Senior Hon. Anaesthetist, University College Hospital.

"The Incidence of Tonsillectomy in School-Children"—by J. Allison Glover, O.B.E., M.D., F.R.C.P., D.P.H.

"Femoral Embolectomy"—by E. N. Wardle, M.B., Ch.B., Liverp., M.Ch. Orth., Liverp., F.R.C.S., Hon. Assistant Orthopaedic Surgeon, Royal Southern Hospital, Liverpool.

"The Journal of Obstetrics and Gynaecology of the British Empire"—December, 1938

William Blair-Bell Memorail Lecture "Uterine Inertia"—by T. N. A. Jeffcoate, M.D., Ch.B. (Liverpool), F.R.C.S. (Edin.), M.C.O.G., Hon. Assistant Surgeon, Liverpool Maternity and Women's Hospital; Hon. Assistant Surgeon, David Lewis Northern Hospital.

"The Interpretation of Radiological Pelvimetry"—by C. Nicholson, M.C., M.A., M.D. (Glas.).

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